Borderline Personality Disorder and Progress in Psychiatry

Jan Fawcett, MD

When I was a resident, we used DSM-I. There was no concept of borderline personality disorder; the disorders were called reactions — eg, depressive reactions.

My memory is that the diagnoses that most frequently were accepted by my supervisors were schizophrenic reaction, passive aggressive personality, histrionic personality, and depressive reaction — later revised in DSM-II as “depressive neurosis.”

The diagnoses were based on psychodynamic observations, and formulations. For example, a loss would lead to a depressive diagnosis, not symptom counts. If the patient experienced a loss, they suffered from depressive reaction or neurosis.

Around 1949, Hoch coined the term “pseudoneurotic schizophrenia,” which was characterized by pan-neurosis and pan-anxiety. Treat patients on the psychoanalytic couch to free-associate, and they would become psychotic, it was said. Around 1962, Greene coined the term “stormy personality,” a difficult-to-manage patient with highly impulsive behavior.

Then in the late 1970s, Gunderson and Grinker wrote about borderline personality disorder (BPD), which was initially seen as an attenuated form of schizophrenia before it was specified as a separate personality disorder. It was characterized by emotional and behavioral dysregulation, resulting in significant impairment. Eventually, based on symptom criteria, BPD was included in DSM-III in 1980.

Now as we look toward the release of DSM-5 in 2013, BPD is being viewed more as a collection of behavioral dimensions, including emotional and behavioral dysregulation. In fact, the concept of diagnosis is becoming increasingly dimensional, as new genetic patterns are discovered and abnormal brain circuitry is observed via neuroimaging. Note that the RDOC proposals for research in the literature are to study domains like genes and circuits — behavioral dimensions instead of categorical diagnoses.

In this issue of Psychiatric Annals, guest edited by S. Charles Schulz, MD, and Katharine J. Nelson, MD, we learn that BPD might have a better long-term prognosis than we originally thought.

It’s been clear for years that our medications don’t treat diagnoses, but are focused instead on behavioral dimensions such as impulsivity, anxiety, depression, psychosis, anger, and mood dysregulation; the FDA only grants support for various disorder categories.

Such developments as those presented here are both strange and wonderful and might, perhaps, even allow us to discover more effective medications.

Psychiatry is making progress, and I’ve had the joy of witnessing its evolution over the years. For that I am very grateful.

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